

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011817

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2012

STATE FILE NUMBER

FILED APR 12 1963

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Holden</u>	
Length of stay in 1b <u>5 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>W. 2nd St.</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arnott</u> Middle <u>Brown</u> Last <u>Newland</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-1876</u>
9. AGE (last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>	
11. BIRTHPLACE (City and state or country) <u>Kingsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Flemon Newland</u>		13b. MOTHER'S MAIDEN NAME <u>Eleanor Skiles</u>	
14. NAME OF HUSBAND OR WIFE <u>deceased.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT Address <u>1015 E. Miss Lois Newland Armour, KC, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Chro Pylonephritis ureteral obstruction at ves. junction</u> DUE TO (c) <u>Papillary tumor of G.T.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>Nov. 1946</u> to <u>3-31-63</u> and last saw her/him alive on <u>3-31-63</u>		Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Dr. Edwin A. Brown MD</u> (Degree or title)		22b. ADDRESS <u>411 Nichols Road</u>	
22c. DATE SIGNED <u>4-1-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	
23b. DATE <u>Apr. 3, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holden Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Holden, Mo.</u>		24. FUNERAL DIRECTOR Address <u>E. B. CAST HOLDEN MO</u>	
25. DATE RECD. BY LOCAL REG. <u>4-1-63</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Edwin A. Brown

APR 15 1963

8-1-12-34

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4054

P. O. Address Holden, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.